Texas Conservative Coalition Research Institute

Comments to the House Committee on Insurance
Response to Request for Information
September 8, 2020

Regarding the following portions of Charge #1: *- Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 86th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure intended legislative outcome of all legislation, including the following:*

SB 1264*, which prohibits balance billing (surprise billing) and creates an arbitration system to settle balance bills. Monitor the implementation of the mediation and arbitration programs, including the establishment of a portal on the TDI website through which requests for mediation and arbitration may be submitted. Determine whether the appropriate state agencies are enforcing the prohibition on balance billing. Review the Department's rules implementing the legislation's exception for non-emergency "elective" services to determine whether the rules limit the exception to out-of-network services that a patient has actively elected after receiving a complete written disclosure. Monitor or follow up on TDI's process for selecting the benchmarking database and determine whether the database chosen provides the most accurate available data and its sources are transparent. Evaluate the fiscal impact of the legislation on the Employees Retirement System of Texas and the Teacher Retirement System of Texas. Review costs to the systems and savings to employees and teachers.*

The Need for SB 1264

In 2016 the total cost of healthcare in the U.S. reached $3.3 trillion[1] and, according to the federal Centers for Medicare and Medicaid Services (CMS), is projected to grow to an astounding $5.7 trillion by 2026.[2] A multitude of factors have contributed to this meteoric rise- some are positive, such as longer life expectancies- while others, such as the growing costs of prescription drugs, larger segments of the population with chronic conditions such as diabetes and heart disease, and intrusive government mandates- are not.

One issue that both increases overall costs and can lead to devastating financial consequences for individual consumers is surprise medical billing, which occurs when patients receive a surprise bill for care from out-of-network providers. Because these providers are outside of a health plan's negotiated network and rates, they can

charge any price for their services, with the patient often left on the hook to pay most, or all, of the bill. Very often, consumers are unaware that such providers are not part of their health plan's network, as a surprise bill can occur when a patient seeks care at an in-network facility (e.g., hospital) only to later learn that the treating provider within that facility (e.g. ER physician, radiologist, anesthesiologist, etc.) was out-of-network (OON).

Although Texas had some safeguards in place to help with surprise billing prior to the 2019 session, there were loopholes that resulted in some Texans continuing to receive astounding medical bills. With stories of staggering surprise medical bills resulting in home liens and crippling debt garnering both state and national headlines,[3] the 86th Legislature passed Senate Bill 1264, a bipartisan measure that closes surprise billing loopholes, requires certain notifications on patient explanation of benefits (EOBs) surrounding such claims, and establishes a framework for health insurers and providers to reach a fair resolution on payment of surprise medical bills through an arbitration process.

TCCRI applauds the leadership and work of this committee on the success of the surprise billing legislation. It is clear that SB 1264 is working for Texas health care consumers. According to the Texas Department of Insurance's (TDI) Six-Month Preliminary Report on SB 1264, "provider complaints about billing disputes have decreased more than 70% from the same period a year ago, and consumer complaints about balance billing have fallen by more than 95%."[4]

Policy Recommendations

TCCRI strongly supported SB 1264 during the 86th Legislative Session, and we have remained engaged throughout the implementation and rulemaking process, offering written comments to TDI and the Texas Medical Board on relevant proposed rules. We will focus our comments to this Committee on three primary topics that mirror those we have provided over the current interim.

- **Address Existing Loopholes Across Regulatory Agencies**

Over the course of TDI's public meetings regarding the implementation of SB 1264, it became very clear that the agency faced a daunting task in implementing this sweeping legislation, in terms of time constraints, the number of stakeholders involved, and the need to coordinate with multiple agencies that oversee various providers impacted by this legislation. While TDI has shouldered the majority of the responsibility for SB 1264 thus far, the agency only has authority for the insurance companies in this scenario. To ensure that the law is thoroughly implemented, the regulatory agencies responsible for licensing impacted providers should also adopt rules that align with SB 1264's language and legislative intent.

- **Ensure Consumers Have Timely and Accurate Information**

TCCRI believes that one of the most powerful antidotes to ever-increasing healthcare costs is greater transparency for healthcare consumers. To that end, TCCRI recommends that any additional rules adopted by regulatory agencies require that consumer notifications contain timely and accurate information, written in plain language, that provide consumers with the information they need to understand costs, what is and is not covered

by insurance, and if exceptions to the balance billing prohibition may apply. Informed consumers are in a better position to harness the power of the free market and, when circumstances allow, comparison shop for best value care.

- **End the Use of Billed Charges as a Benchmark Standard in the Arbitration Process**

Texas Insurance Code §1467.083(b)(6) requires that an arbitration determination must, among other things, take into account, "the 80th percentile of all ***billed*** charges for the service or supply performed by a health care provider in the same or similar specialty and provided in the same geozip area…" (emphasis added). This standard can skew the starting point upon which the arbitration process is based and further contribute to the lack of transparency and tangible data within health care pricing.

In a truly free market, the value, or price, of a good or service is determined by what someone pays for that good or service, not the original asking price. While the asking price and amount paid may be one and the same, this is not always the case. That is why Relators® and mortgage lenders look to the price at which homes actually sell, and not their listing prices, to determine appropriate comps and appraisal amounts.[5] To look at only the list prices could artificially drive up property appraisals and, hence, property taxes, while being far removed from what actually occurs in the property market between willing buyers and sellers.

The same is true in the health care marketplace. A provider may bill any amount that he or she wishes, regardless of whether that amount is tied to any standard of reasonableness or "fair" market value. And, when this billed charge becomes a benchmark upon which arbitration or penalties is based, the result will only serve to artificially, and unnecessarily, inflate health care costs, which in turn negatively impacts employers, consumers, and taxpayers alike. A 2019 report by the Center for Health Policy at Brookings on surprise OON billing points out that, "basing an out-of- network charge limit on billed charges would likely lead to too high a limit and drive up health costs and insurance premiums."[6]

Similarly, a report on New York's process of using billed charges as a standard for Informal Dispute Resolution (IDR) for out-of-network (OON) posits:

> Because providers can set their charges as high as they see fit and IDR ensures they will be paid at that level as long as they are out-of-network, it is not surprising that most observers expect New York's IDR-based approach will result in higher health care costs.[7]

These predictions have proven true in Alaska, where the state's Office of Management and Budget asked researchers at the University of Alaska (Anchorage) to look at the impact of its rule using the 80% of billed charges standard in settling disputed OON claims. The 2018 report found that this rule alone accounted for anywhere between 8 percent and 25 percent of annual growth in Alaska's health care spending.[8]

Using billed charges as a standard can also encourage providers to continue to increase their billed charges in an attempt to raise arbitration settlement amounts. This creates a self-perpetuating cycle that only serves

to hurt the everyday health care consumer and moves today's market further and further away from actual transparent costs.

Removing arbitrary billed charges amounts as a standard will result in more accurate, market-based outcomes in surprise billing arbitration processes. This will help move the marketplace toward the widely shared goal of determining the actual costs of health care services and, based on Alaska's experience, could even contribute to lowering overall health care costs.

ENDNOTES

[1] U.S. Centers for Medicare and Medicaid Services, "National Expenditures 2016 Highlights," available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf

[2] U.S. Centers for Medicare and Medicaid Services, "National Expenditure Projections 2017-2026," available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf.

[3] See NBC News, "Surprise medical bills lead to liens on homes and crippling debt," by Lindsey Bomnin and Stephanie Gosk, March 19, 2019, available at https://www.nbcnews.com/health/health-news/surprise-medical-bills-lead-liens-homes-crippling-debt-n984371. *See also* Dallas Morning News, "Texas teacher with $108k medical tab caught in surprise hospital billing loophole that creates havoc," by Chad Terhune for Kaiser Health News, August 28, 2018, available at https://www.dallasnews.com/business/health-care/2018/08/28/texas-teacher-with-108k-medical-tab-caught-in-surprise-hospital-billing-loophole-that-creates-havoc/.

[4] Texas Department of Insurance, "Senate Bill 1264: Six Month Preliminary Report," July 2020, available at: https://www.tdi.texas.gov/reports/documents/SB1264-preliminary-report.pdf.

[5] See Zillow, "Real Estate Comps: How to Find Comparables for Real Estate." Available at: https://www.zillow.com/sellers-guide/real-estate-comps/.

[6] Adler, L., et. al. "State Approaches to Mitigating Surprise Out-of-Network Billing." Center for Health Policy at Brookings. February 2019. Available at: https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf.

[7] Brannon, Ike and Kemp, David. "The Potential Pitfalls of Combatting Surprise Billing." *Cato Institute*. November 2019. Available at: https://www.cato.org/sites/cato.org/files/2019-10/regulation-v42n3-1-updated.pdf.

[8] Guettabi, M. "How Has the 80th Percentile Rule Affected Alaska's Health-Care Expenditures?". University of Alaska Anchorage. Report prepared for Alaska Office of Management and Budget. May 16, 2018. Available at: https://pubs.iseralaska.org/media/cb1873a4-05c6-4def-9ace-cbe5b1f77f97/2018_05_29-80thPercentileReport.pdf.